Field Advisory Services - *FAS*
Benefits & Entitlements Branch
Disability Information Sheets

Fax-Back #217 thru 252

The Benefits and Entitlements Branch of the Field Advisory Services Division, DoD, in cooperation with the Office of Personnel Management (OPM), have prepared the attached "Disability Information Sheet(s)". We encourage employees and their treating physicians to use these sheets to help them with the medical documentation needed to support the employee's application for disability retirement.

One of the criteria to qualify for disability retirement is the presence of a medical condition. OPM defines medical condition as a disease or injury. The terms listed on the Information Sheet(s) can help the employee and his physician(s).

We hope the Information Sheet(s) will help avoid delays in OPM's processing of an application that can result when medical documentation is needed. The sheets are simply an aid; using them does not guarantee approval of any application but should help the employees and doctors in documenting the medical condition of the employee.

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DISABILITY INFORMATION SHEET
FOR ALLERGIES

Fax-Back #218

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

When did the symptoms begin? Describe their nature, please. Did the symptoms develop after starting a new job or after new materials were introduced? Did the symptoms develop within minutes of specific activities or exposure at work? Is there a history of a high level acute exposure? Do delayed symptoms occur? Describe, please. Do symptoms occur less frequently or not at all on days away from work and on vacation? Do symptoms occur more frequently on returning to work? Any history of atopy? Describe. Smoking history? Occupational history?

Have the following other clinical disorders been excluded? Autoimmune disease? Infectious disorders? Psychiatric disorders? Chronic inflammatory disorders? Endocrine disorders? Intoxications? Side effects of medications? Drug dependency? (Please describe in some detail for each condition.)

PHYSICAL EXAMINATION:

Results of a complete physical examination with emphasis on the respiratory and nervous systems.

LABORATORY STUDIES: (If performed)

Dynamic pulmonary function tests with and without bronchodilator? Static pulmonary function tests including DLCO. Inhalation challenge testing? Results of skin testing? RAST tests? Results of peak expiratory flow rates while at work and away from work. Copies of MSDS for substances used at work? Results of recent industrial hygiene surveys for the work place. CBC? Sedimentation rate? X-rays? ANA? PPD? Serum electrolytes/ glucose; creatinine and blood urea nitrogen; calcium & phosphorus; alkaline phosphatase and total bilirubin; serum aspartase serum aspartase aminotransferase; serum alanine aminotransferase; creatine phosphokinase? Urinalysis? (Please provide copies of reports.)

THERAPY:

Medications? Other treatment? Immunotherapy? Respirator use? Restrictions? (Please describe in detail.)

DISABILITY INFORMATION SHEET FOR APNEA & NARCOLEPSY

Fax-Back #219

***NAME:*_____**

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

When did symptoms begin? Is there heavy snoring? Is snoring intermittent with periods of respiratory silence? Is there motor restlessness? Is daytime somnolence present? Headaches? Depression? Is the patient taking drugs which may cause this problem such as hypnotics? Is alcohol use common before bedtime? Does sleep partner complain of snoring or describe other symptoms Family history of sleep disorders? Does patient have Down's syndrome acromegaly, myxedema, or upper or lower respiratory disease? History of sudden, brief sleep attacks? Cataplexy? Sleep paralysis? Hypnogogic hallucinations?

PHYSICAL EXAMINATION:

Height and weight. Is neck short and obese? Is there tonsillar or adenoidal hypertrophy? Is there narrowing of the pharynx? Are vocal cords normal? Blood pressure? Is there evidence of neurological deficit?

LABORATORY STUDIES: (If performed)

Sleep studies? Do these show an excessive number of periods of arousal or other sleep disturbance? Is sleep latency normal? Evidence of oxygen desaturation of arterial blood? Arrhythmias or bradycardia or other cardiac abnormalities? Motor restlessness? HLA? DR2? EEG?

THERAPY: **(Please also describe patient compliance and response to therapy)**

Weight loss? Uvulopalatoplasty or palatopharyngoplasty or other surgery? Continuous positive airway pressure? Tracheostomy? Have any other diseases which may contribute to this condition been treated fully? Other? Medications? (Please describe)

DISABILITY INFORMATION SHEET FOR ASTHMA

Fax-Back #220

***NAME:*_____**

To assist in submitting information regarding the history, symptoms, physical findings, results of laboratory studies and therapy on this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

When did the respiratory symptoms begin? Cough? (Productive or non-productive, time of day, etc.) Dyspnea? (Time of day, how many blocks can be walked, how many stairs can be climbed, etc.) Wheezing? (Time of day, week, etc.) Frequency of asthmatic attacks? Frequency of episodes of asthma requiring hospitalization or emergency treatment? Frequency and nature of respiratory infections? Allergic history?

PHYSICAL EXAMINATION:

Results of a complete physical examination with emphasis on the respiratory system.

LABORATORY: (If performed)

Dynamic pulmonary function tests with and without bronchodilators? Static pulmonary function tests including DLCO. Inhalation challenge testing? Results of skin testing? RAST tests? (Please provide copies of reports.) Results of peak expiratory flow rates?

THERAPY:

Medications? Immunotherapy? Respirator use? Restriction? (Please describe.) Response to therapy.

DISABILITY INFORMATION SHEET
FOR CARDIAC DISEASE

Fax-Back #245

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY			
	Dyspnea (whether at rest, on exercise, how many blocks can be walked, how many stairs walked up, orthopnea)		Palpitations, irregular pulse, arrhythmias
	Edema of the feet, ankles, legs		Dizziness, fainting
	Cough (sputum production, hemoptysis, etc.)		Smoking history (packs-years)
	Chest pain (where, when, what makes it worse or better, etc.)		New York Heart Association Classification
			Other

PHYSICAL FINDINGS			
	Lung examination (rates, rhonchi, loss or decrease in breath sounds)		Heart examination (size, apical impulse, rate, rhythm, character of sounds, murmurs)
	Blood pressure		Thrills, carotid bruits, jugular vein distension
	Edema of the feet, legs		Cyanosis
			Other

LABORATORY STUDIES			
	Electrocardiogram		Scintigraphy, MUGA scans
	Exercise testing		Enzymes
	Catheterization		Echocardiogram
	Holter monitoring		Chest X-ray
	Coronary arteriogram		Other

THERAPY			
Frequency and dosage should be described. Describe response to therapy and the patient's compliance with therapy.			
	Medications		Operative summaries
	Physical therapy, exercise training		Restrictions
	Cardiac pacing		Please explain the physiologic basis for the restrictions
	Summaries of hospitalizations		Other

DISIABILITY INFORMATION SHEET FOR CARPAL TUNNEL SYNDROME

Fax-Back #221

***NAME:*_____**

To avoid submitting inadequate information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy of this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Additional information may be needed regarding:

HISTORY:

Nature and location of current symptoms, e.g. pain, numbness, paresthesia, weakness, clumsiness, etc.? (Please describe in detail.) If there is pain, does it radiate proximally and, if so, to where? Is the patient awakened by the pain? What activities aggravate or produce symptoms and which alleviate symptoms? Is there a history of repetitive use of the hands? Any family history of CTS? Any history of diabetes, rheumatoid arthritis, amyloidosis, sarcoidosis, hyperparathyroidism, myxedema, trauma to the hand or wrists, etc?

PHYSICAL EXAMINATION:

Describe the areas of pain or tenderness? Any deformities? Any changes in sensation to pinprick, two point discrimination and vibration? (Please describe the distribution.) Any thenar atrophy? Any motor weakness? (Please describe.) Finklestein's Sign? Tinel's Sign? Phalen's Sign?

LABORATORY STUDIES:

EMG/NCV? Sedimentation Rate? ANA? Rheumatoid factor? X-rays? MRI? Etc? (Please provide copies of reports.)

THERAPY:

Please describe in detail. Medications? Splints? Steroid injections? Physical therapy? Describe changes that have been made in the work place such as tilting of work surface, keyboard, display terminal, hand or arm rests; changes in tool design or arrangement, changes in the frequency of the repetitive cycle, etc? Please describe any restrictions that have been imposed?

DISABILITY INFORMATION SHEET
FOR CHRONIC FATIGUE SYNDROME

Fax-Back #222

NAME:_____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

Date of onset of fatigue? Severity? History of low grade fever? Sore throat? Painful lymph nodes? Muscle weakness? Myalgias? Headache? Sleep disturbances? Arthralgias? Neuropsychologic complaints? Fibromyalgia? Adequately treated toxoplasmosis, brucellosis, or Lyme borreliosis? Nonpsychotic depression, somatoform disorders, generalized anxiety or panic disorders? If psychiatric disease is present, has it been treated and, if so, have CFS symptoms abated along with other symptoms?

Have the following other clinical disorders been excluded? Autoimmune disease? Chronic active hepatitis B or C? Inadequately treated Lyme borreliosis? HIV infection? Tuberculosis? Other infectious disease? Psychotic depression, bipolar disorder, or schizophrenia? Substance abuse? Malignancy? Chronic inflammatory disorders? Neuromuscular diseases? Endocrine disorders? Intoxications? (Please describe in some detail for each condition.)

PHYSICAL EXAMINATION:

Fever? (Please provide serial AM and PM temperature measurements.) Non-exudative pharyngitis? Palpable and/or tender cervical nodes? Weight, measured serially? Results of a complete current physical examination?

LABORATORY STUDIES:

Blood work? (Complete blood count and differential; serum electrolytes; glucose; creatinine; BUN; calcium; phosphorus; total bilirubin; alkaline phosphatase; serum aspartate aminotransferase; serum alkaline aminotransferase; creatine phosphokinase or aldolase; erythrocyte sedimentation rate; antinuclear antibody; thyroid stimulating hormone? HIV antibody measurement? Intermediate strength PPD? X-rays? Urinalysis? Neuropsychological testing? Other tests to rule conditions listed under the history?

THERAPY:

Medications? Other treatment? (Please describe in detail.) Hospitalizations? (Please provide summary.)

DISABILITY INFORMATION SHEET
CUMULATIVE TRAUMA INJURY

Fax-Back #223

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

When did the symptoms begin? Describe the nature, location and severity of symptoms. Are there paresthesia? Where? What activities help and which aggravate the symptoms? Does the patient's job require: frequent repetitive use of the same or similar movements of the affected joints(s) or anatomic area? Maintaining force with the hand(s) at or above the shoulder level? Regular or sustained task in awkward position? Regular use of vibrating tools or prolonged pressure over the wrist or palm? or frequent or continuous exposure to cold air or gripping cold tools, hand controls, equipment, etc?

PHYSICAL EXAMINATION:

Describe the areas of pain or tenderness. Are any deformities noted? Describe the range of motion of the affected parts in degrees. Is muscle spasm present? Is there any crepitance, effusion of soft tissue swelling? Describe muscle power. If weakness is present, is it of the "give way" or "voluntary release" type? Is there any evidence of muscle atrophy? Neurological examination as appropriate (sensation, vibration, heat, cold, Tinel's sign, Phalen's sign, shoulder abduction test, etc.).

LABORATORY STUDIES:

Please include copies of reports. X-rays, MRI, CT Scan, Bone Scan, EMG, NCV? ANA, sedimentation rate rheumatoid factor, etc.?

THERAPY:

Splints, braces or other supports? Medication? Physical therapy? Exercises? (Describe in detail) Hospitalizations or operations (Provide copies of summaries)?

CHANGES IN THE WORK PLACE:

What changes have been made to reduce postural strain (decreased reach, height of chair or work surface, tilting of work surface, keyboard, hand or arm rests, etc.?) What changes have been made to tool design or arrangement? Could power tools be used instead of hand tools? Have changes been made in the frequency of the repetitive cycle?

DISABILITY INFORMATION SHEET FOR DIABETES

Fax-Back #246

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY			
	How long has the disease been present?		Visual symptoms?
	Frequency and severity of the episodes of ketoacidosis and/or hypoglycemia?		Parasthesias or other symptoms of neuropathy?
	Claudication, angina, MI's, strokes, small vessel disease, etc.		Skin problems (e.g. pruritus, infections, gangrene, etc.)
	Does the patient routinely monitor glucose levels?		Diarrhea, constipation, postural hypotension, urinary retention, etc.
			Other

PHYSICAL FINDINGS			
	Weight		Eye and fundoscopic examination
	Blood pressure		Peripheral pulses
	Pulse		Capillary refill time
	Complete neurological examination		Skin ulceration infections, etc. (If present, size, location, etc.)
			Other

LABORATORY STUDIES			
	Fasting and postprandial plasma glucose levels		EMG's/Nerve conduction velocity
	Glucose tolerance test		Bladder function
	Cholesterol		Arteriogram
	Other blood lipids		Doppier testing of the peripheral circulation
	Electrocardiogram		Ophthalmological examinations
	Tests of renal function (i.e. BUN, Creatinine, Albuminuria, urine specific gravity, etc.)		Radiographs of the chest, abdomen, extremities, etc.
	Glycohemoglobin		Other

THERAPY			
Frequency and dosage should be described. Describe response to therapy and the patient's compliance with therapy.			
	Weight reduction		Other treatment modalities
	Diet		Exercise
	Oral hypoglycemic agents		Hospitalization(s) Please include reports.
	Insulin (What type, how much, and how frequently)		How well controlled is the diabetes?
	Restrictions		Other

DISABILITY INFORMATION SHEET FOR DYSTROPHY

Fax-Back #224

NAME:**_____**

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

Location and nature of the pain? Duration of pain? History of trauma? (Please describe). History of any psychiatric disorders?

PHYSICAL EXAMINATION:

Any skin changes, e.g. cold, cyanotic, sweaty or warm, dry and red, etc.? Increased or decreased hair growth? Changes in nail growth, e.g. split or ridged, etc.? Range of motion of the affected joints (both active and passive). Any atrophic skin changes? Edema? (Please describe). Any muscle atrophy? Any tapering of digits?

LABORATORY STUDIES: (If performed)

Skin temperature? Thermography? Skin blood flow? Sweat tests? X-rays? Bone scans? Etc.? (Please provide copies of reports).

THERAPY:

Oral medications? (Please describe). Physical therapy? Sympathetic blockade? (Please describe the response). Surgical sympathectomy? Etc.?

DISABILITY INFORMATION SHEET FOR EOSINOPHILIC MYALGIA SYNDROME

Fax-Back #225

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

Date of onset of symptoms? Nature of symptoms? (Please describe in detail) Myalgia? Arthralgia? Dyspnea? Cough? Rashes? (Please describe in detail) History of L Tryptophan ingestion? When and for how long? Other symptoms?

PHYSICAL EXAMINATION:

Edema? (Describe in detail) Fever? Skin changes? (Please describe in detail) Hair loss? Sensory changes? Describe in detail. Other? (Please describe).

LABORATORY STUDIES: (If performed)

CBC? EMG/NCV? Pulmonary Function studies? Chest X-rays? Sedimentation rate? ANA? Creatine Kinase? Liver function studies? Lever biopsies? Please provide copies of all reports.

THERAPY:

Please describe in detail. Medications? Etc.?

DISABILITY INFORMATION SHEET FOR ESOPHAGITIS

Fax-Back #226

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

Pyrosis? (Please specify the severity). When does it occur? What's the temporal relationship to eating? Effects of recumbency and of sitting upright? Any radiation of the pain? If so, where? (Please specify). History of nausea and/or vomiting? History of water brash? Hoarseness? (Please describe). Globus? Dysphagia? Hematemesis? Melena? Anemia?

PHYSICAL EXAMINATION:

Results of a complete physical examination with emphasis on the abdomen. If there is significant laryngeal involvement, please include findings pertaining to the head and neck. Height and weight?

LABORATORY STUDIES: (If performed)

Upper GI series? Barium swallow? Acid perfusion test? Endoscopy? Esophageal Ph monitoring? Biopsy? Evaluations by speech pathologists if hoarseness is present. (Please provide copies of reports).

THERAPY:

Medications? (Please specify). Diet modification? Tobacco and alcohol abstinence? Weight reduction if indicated? Elevation of the head of the bed? Speech therapy? Other? (Please specify).

DISABILITY INFORMATION SHEET FOR EYE DISORDERS

Fax-Back #227

***NAME:*_____**

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

When did visual symptoms first develop? Any changes in visual acuity? When was it first noted? Any photophobia? Any halos or rings around lights? Any difficulty seeing in the dark? Any momentary loss in vision? (Describe in detail, please.) Any pain in eye(s)? Headache? Any swelling or redness of eyes? Discharge (Describe, please.) Diplopia? Vertigo? Increased or decreased lacrimation?

PHYSICAL EXAMINATION:

Visual acuity, far and near, corrected and uncorrected? Condition of external ocular structures? Pupillary size, shape and reaction to light and accommodation, etc.? Size, prominence, and position of eyes? Strabismus? Nystagmus? Visual fields by confrontation? Extraocular motion? Fundoscopic examination?

SPECIAL STUDIES: (If performed)

Slit lamp examination? Perimetry? Tonometry? Gonioscopy? Keratoscopy? Ophthalmoscopy? Fluorescein angiography? Toxoplasmosis antibody tiers?

THERAPY:

Medications? Corrective lenses? Surgery? (Please provide copies of operative reports.) Hospitalizations? (Please provide copies of discharge summaries.) Etc.?

DISABILITY INFORMATION SHEET FOR FIBROMYALGIA

Fax-Back #228

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

Location of pain? (Please describe in detail) Nature and duration of pain(s). Any stiffness? (When is it most pronounced and how long does it last?) What exacerbates symptoms and what helps them? Fatigue? Tiredness? Chronic headaches? Quality of sleep? Subjective swelling? Numbness? Abdominal discomfort? Abdominal bloating? Diarrhea? Constipation? History of anxiety? Depression?

PHYSICAL EXAMINATION:

Results of a comprehensive physical examination. Any trigger point tenderness? Where?

LABORATORY STUDIES: (If performed)

CBC? Sedimentation rate? Rheumatoid factor? ANA? T4? T3 uptake? TSH? X-rays? (Please provide copies of laboratory study reports.)

THERAPY:

Trigger point injections? Stretch and spray therapy? Muscle stretching exercises? NSAID's? Amitriptyline? Prozac? Doxepin? Flexeril? Physical therapy? Psychotherapy? Etc.?

DISABILITY INFORMATION SHEET FOR HEADACHES

Fax-Back #229

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

What is the character of the headache pain? (i.e. location, severity, frequency, throbbing or steady, etc.) Are there any visual or other prodrome? (Describe) When do the headaches occur? What factors make the headache better or worse? How long does the headache last? Does medication affect the headache? Is there a history of any psychiatric conditions such as depression, etc.? (Describe) Any history of head trauma? (Describe) Are the headaches accompanied by Fatigability? Irritability? Difficulty concentrating? Any history of seizures? (Describe) Any history of sinusitis or other upper respiratory conditions? History of Glaucoma?

PHYSICAL EXAMINATION:

A complete neurological examination is needed. Any scalp/head tenderness? Any bruits? Any sign of autonomic dysfunction during the headaches?

LABORATORY STUDIES:

If performed, describe the results of: EEG? CT Scan of the head? X-rays of the head? MRI of the head? Other studies? (Please provide copies of reports.)

THERAPY:

Medications? Relaxation techniques? Massage? Heat? Exercise? Etc.?

DISABILITY INFORMATION SHEET FOR HYPERTENSION

Fax-Back #247

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY			
	Date of onset of disease/diagnosis		Symptoms referable to peripheral vascular disease
	Symptoms referable to cardiac disease		Symptoms referable to neurological disease
	Symptoms referable kidney disease		Other

PHYSICAL FINDINGS			
	Blood pressure readings (At work, at home, MD's office. Any significant difference between arms, etc.)		Eyes (retinopathy)
	Peripheral vascular signs (pulses, skin changes, temperature of skin, ulcers, etc.)		Kidneys (edema, itching)
	Heart (size, rhythm, murmurs, etc.)		A neurological examination of effected areas
			Other

LABORATORY STUDIES			
	Blood pressure readings		Exercise testing
	Electrocardiogram		Arteriograms (coronary, renal carotid, etc.)
	Blood tests for renal function (BUN, creatinine, etc.)		CT scan of brain
	Chest X-ray		24 hour blood pressure recording
	Visual acuity/visual fields, etc.		Echocardiogram
	Renal function studies		Electroencephalogram
	Renal perfusion studies		Other

THERAPY			
Frequency and dosage should be described. Describe response to therapy and the patient's compliance with therapy.			
	Medications		Restrictions
	Weight reduction		Salt restriction
	Summaries of hospitalizations		Please explain the physiological basis for the restrictions
	Operative summaries		Other

DISABILITY INFORMATION SHEET FOR INTESTINAL DISORDERS

Fax-Back #230

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

Date of onset of symptoms? Abdominal pain? (Please describe the nature, location, severity, etc. Vomiting? Diarrhea? Constipation? Frequency and duration of exacerbations and remissions per year? Anorexia? Weight loss? Malaise? Fever? Flatulency? History of obstruction? History of Fistulas? Arthralgia? Family history of intestinal disease? Any foods which aggravate the symptoms? (Please describe).

PHYSICAL EXAMINATION:

Results of a complete physical examination. Abdominal tenderness? (Location, degree, etc. Please describe in detail) Abdominal masses? Bowel sounds? Abdominal distention? Fever? Synovitis? Other?

LABORATORY STUDIES: (If performed)

CBC? Serum chemistries? Radiographs, CT Scans, or MRI of the abdomen? Small bowel barium series? Barium enema? Endoscopic studies? Fecal fat analysis? Cultures? Stool parasites? Biopsies? Other? (Please provide copies of reports.)

THERAPY:

Diet? (Please describe) Vitamins? Medication? (Please describe in detail) Surgical procedures? (Please provide copies of operative reports) Hospitalizations (Please provide copies of discharge summaries.)

DISABILITY INFORMATION SHEET
FOR IRRITABLE BOWEL SYNDROME

Fax-Back #231

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

Any abdominal pain? (Nature, duration, frequency, location, etc. Please describe in detail. Constipation/diarrhea? (Nature, frequency, etc. Please describe in detail.) Any blood or mucus in stools? Flatulence? Nausea? Anorexia? Abdominal fullness? History of any affective disorders? (Please describe)

PHYSICAL EXAMINATION:

Results of complete physical examination. Abdominal tenderness? (Location, degree, etc. Describe in detail) Bowel sounds? Abdominal masses?

LABORATORY STUDIES: (If performed)

Barium enema? Sigmoidoscopy? Blood in stools? Stool for ova, parasites, etc? Stood culture? Psychosocial evaluation? (Please provide copies of reports)

THERAPY:

Diet? (Dietary fiber, exclusion of dairy products, etc?) Medications? Vegetable mucilages? Psychotherapy? Etc.?

DISABILITY INFORMATION SHEET
FOR LIVER DISORDERS

Fax-Back #232

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

History of hepatitis? Jaundice? Weight loss or gain? Change in color of stool? Fatigability? Nausea? Vomiting? Abdominal pain? Oliguria? Hematemesis? Alcohol use? (How much?) Smoking history in pack years? History of lever or gall bladder disease in the family? History of drug use? Medications? Past occupational history in detail? Hobbies? (Describe) Residential characteristics? History of blood transfusion? Copies of Material Safety Data Sheets for substances used in the work place? Results of last two industrial hygiene surveys of work place? (Please provide copies of reports). Personal protective equipment used in work place? (Describe)

PHYSICAL EXAMINATION:

Results of current, complete physical examination. Hepatomegaly? Splenomegaly? Ascites? Jugular distention? Spider nevi? Palmar erythema? Telangiectases? Glossitis? Cheilosis? Jaundice? Evidence of pruritus? Pleural effusion? Purpura? Tremor? Dysarthria? Asterixis? Peripheral edema?

LABORATORY STUDIES: (If performed)

Results of serological tests for hepatitis A, B, & C. Results of CBC including MCV & HCH. Bilirubin, direct & indirect? GGTP? Albumin? Globulin? LDH? Clearance tests? Coagulation studies? SGOT? Alkaline Phosphatase? Abdominal X-rays? Barium Upper GI Studies? Splenoportography and/or arteriography? Hepatic scans? Esophagogastroscopy? Liver biopsy? (Please provide copies of reports)

THERAPY:

Medications? Other treatment? Immunotherapy? Respirator use? Restrictions? (Please describe in detail.)

DISABILITY INFORMATION SHEET
FOR LUMBOSACRAL DISORDERS

Fax-Back #248

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY			
	What sort of activity or motion caused the initial attack?		What activities help and which aggravate the symptoms?
	Describe the nature, location, and severity of the symptoms.		Is there pain in the leg, ankle or foot? Is there radiation? Is it lancinating?
	Are the symptoms intermittent or constant?		Are there paresthesias? Where?
	Do they change with coughing, sneezing, straining at stool?		Is there pain when the patient arches backward?
			Other

LABORATORY STUDIES			
	X-rays		Bone scan
	CT Scan		Sedimentation rate
	MRI		White blood count
	Myelogram		Discography
	EMG's		Venography
			Other

PHYSICAL FINDINGS

	Patient's weight, height and body build?		Toe walking? Rise up and down on toes 10-12 times?
	Describe the patient's gait.		Heel walking?
	Alignment of the spine straight? Any scoliosis?		Evidence of muscular atrophy? Circumference of thigh and calf?
	Location and severity of tenderness, if any? Is it diffuse or localized to one structure? Is the skin tender to pinch?		Muscle weakness? If present, which muscles are involved? Is the weakness of the "voluntary release" or "give away" type?
	Presence and location of spasm, if present?		Can the patient do deep knee bends on one side and then the other?
	Supine and sitting straight leg raising tests and other stretch tests, such as contralateral straight leg raising, etc. (Please describe the endpoint that is used.)		Results of tests of sensation? (Touch, pinprick, position, temperature, and vibration) Location and distribution Is it dermatomal? Is it "stocking"?
	Result of congruency tests? (E.g., Axial loading, rotation, sitting vs. Supine straight leg raising, distraction, Hoover, voluntary release, etc.)		Deep tendon reflexes
	Babinski		Other

OTHER STUDIES

Because environmental, behavioral and social factors can play an extremely important role in the pathogenesis of lumbosacral disorders, clarification of the extent of emotional disturbance, if any, created by this disorder may be needed by means of a psychosocial assessment by a psychiatrist.

THERAPY

Frequency and dosage should be described. Describe response to therapy and the patient's compliance with therapy.

	Bedrest		TENS
	Physical Therapy		Psychotherapy
	Exercises		Weight reduction (if indicated)
	Medications (i.e., anti-inflammatory, analgesics, steroids, muscle relaxants, etc.)		Pain clinic
	Traction		Steroid injections

	Manipulation		Surgical procedures (Please include operative reports).
	Braces and/or corsets		Restrictions
	Hospitalization(s) Please include reports.		Please explain the physiological basis for these restrictions.
	Back School		Other

DISABILITY INFORMATION SHEET FOR LYME DISEASE

Fax-Back #235

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

History of tick bite? (When?) Any skin rash(es)? (Please describe) Malaise? Fatigue? Fever? Chills? Headache? Stiff neck? Backache? Myalgia? Arthralgia? (If so, what joints were involved and what is the duration of the episodes?) Nausea? Vomiting? Cardiac symptoms? Sleep disturbances? Difficulty in concentration? Memory impairment? Depression? Paresthesia? Any paralysis? (Please describe>) Dizziness? Vertigo? Changes in hearing? Visual problems?

PHYSICAL EXAMINATION:

Results of a complete physical examination with particular attention to:

- Skin--Any lesions? (Please describe)
- Chest--Areas of dullness? Increased or decreased breath sounds? Friction rubs, rales, rhonchi, wheezes, etc.?
- Cardiac--Size, apical impulse, rate, rhythm, character of sounds, murmurs, S3, etc? Nature of venous pulse waves?
- Musculoskeletal System--Joint contours? Location and severity of tenderness? Cysts? Crepitance? Effusion? Erythema? Range of motion of affected joints?
- Neurological System--Mental status exam? Cranial nerves? Sensory or motor changes? Test of coordination? Ataxia? Pathological reflexes or signs?

LABORATORY STUDIES: **(If performed, please provide copies of report.).**

CBC? Sedimentation rate? ANA? Rheumatoid factor? Serologic tests? Immunoglobulin levels? X-rays? MRI? Electrocardiogram? Echocardiogram? Other?

THERAPY:

Medications? (Please specify) Other?

DISABILITY INFORMATION SHEET FOR MULTIPLE SCLEROSIS

Fax-Back #236

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

History of diplopia? Blurred vision? Loss of vision? Sensory symptoms? (Describe location, nature, etc.) Speech difficulties? Gait disturbances? Urinary urgency, hesitancy or incontinence? Disequilibrium? Fatigue? Motor weakness? (Please describe) Disturbances of coordination? (Please describe).

PHYSICAL FINDINGS:

Results of a complete physical examination with emphasis on the nervous system. Pallor of the optic disk? Internuclear ophthalmoplegia? Cerebellar ataxia? Dysarthria? Hyperreflexia? Spasticity? Weakness? Lhermitte's sign? Nystagmus?

LABORATORY STUDIES: (If performed)

MRI? CT Scan? CSF studies? Somatosensory evoked responses. Visual evoked responses? Auditory evoked responses? Other? (Please provide copies of reports?)

THERAPY:

Medications? (Please describe) Supportive? (Please describe) Hospitalizations? (Please provide copies of discharge summaries)

CLINICAL COURSE:

Describe in detail the clinical course of this condition in this patient, e.g. frequency and duration of relapses and remissions, etc.

DISABILITY INFORMATION SHEET FOR MUSCULOSKELETAL DISORDERS

Fax-Back #251

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY			
	Location, distribution and nature (e.g., sharp, dull, intermittent, constant, etc.) of the pain.		Any stiffness of the joint? When in the day is it better and when is it worse?
	What movements and activities produce or aggravate the pain?		Nature and distribution of the radiation, if present.
	Any locking of the joint?		History of previous injury to the joint.
	Any history of swelling or redness of the joint?		History of weakness?
	Parasthesias? If so, distribution, nature, etc.		Other

LABORATORY STUDIES			
	X-rays		Arthroscopy
	CT Scan		Sedimentation rate
	MRI		ANA
	Bone scan		Rheumatoid factor
	Arthrocentesis		Arthrograms
			Other

PHYSICAL FINDINGS			
	Bone and soft tissue contours		McMurray's (special test)
	Deformity		Lachmann's (special test)
	Location and severity of tenderness		Lateral pivot (special test)
	Cysts		Yergason's sign (special test)
	Muscle spasm?		Effusion?
	Tests of stability?		Peripheral pulses
	Range of motion (both active and passive) in degrees as appropriate for the joint in question (abduction, adduction, flexion, extension, internal rotation and external rotation. Also, pronation and supination for the elbow).		Muscle power (in the same planes of direction as for range of motion for the joint in question). If muscle weakness is present, is it of the "voluntary release" or "give away" type?
	Evidence of muscle atrophy? Measure the circumference of the appropriate limb(s).		Neurological examination as appropriate (Sensation, deep tendon reflexes, pathological reflexes, etc.)
	Stance and gait		Other

THERAPY			
Frequency and dosage should be described. Describe response to therapy and the patient's compliance with therapy.			
	Splints		Weight reduction
	Braces		Exercises
	Medications (e.g., anti-inflammatory, analgesics, steroids, etc.)		Hospitalization(s) (Please include copies of reports).
	Physical Therapy		Restrictions
	Operative procedures (Please include copies of reports).		Please explain the physiological basis for the restrictions.
	Manipulation		Other

DISABILITY INFORMATION SHEET
FOR NECK DISORDERS

Fax-Back #249

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY

	What sort of activity or motion caused the initial attack?		What activities help and which aggravate the symptoms?
	Describe the nature, location, and severity of the symptoms (e.g., pain and stiffness).		Is there pain in the shoulder or arm? Is there radiation?
	Are they intermittent or constant?		Is there any paresthesias? Where? Is the distribution dermatomal?
	Do they change with coughing, sneezing, or straining at stool?		Other

LABORATORY STUDIES

	X-rays		EMG's
	CT Scan		Bone Scan
	MRI		Sedimentation rate
	Myelogram		Other

PHYSICAL FINDINGS			
	Range of motion of the cervical spine in degrees. (Rotation, flexion and extension, lateral flexion, both active and passive).		Muscular weakness? Which muscles are involved? Is the weakness of the "give away" or "voluntary release" type?
	Location and severity of tenderness, if any? Is it diffuse or limited to anatomic structures?		Results of tests of sensation? (Touch, pinprick, position, vibration, and temperature). Location and distribution. Is it dermatomal?
	Presence and location of spasm, if present?		Deep tendon reflexes?
	Crepitation		Cranial nerves
	Spurling's test		Babinski
	Evidence of muscular atrophy? Circumference of upper arm and forearm		Hoffman
			Other

THERAPY			
Frequency and dosage should be described. Describe response to therapy and the patient's compliance with therapy.			
	Bedrest		Pain clinic
	Physical therapy		TENS
	Traction		Surgical procedure(s). Please include the operative report(s).
	Cervical collar		Hospitalization (Please include the report).
	Manipulation		Restrictions (workplace, recreational, at home)
	Medication (e.g., anti-inflammatory, analgesics, steroids, muscle relaxants, etc.)		Please explain the physiological basis of the restrictions.
	Steroid injections		Other

DISABILITY INFORMATION SHEET FOR OCCUPATIONAL ASTHMA/REACTIVE AIRWAY DISEASE

Fax-Back #244

NAME: _____

To assist in submitting information regarding the history, symptoms, physical findings, results of laboratory studies and therapy on this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain information from your treating physician(s). More specific information may be needed regarding:

HISTORY:

When did the respiratory symptoms begin? Describe their nature. Did the symptoms develop after starting a new job or after new materials were introduced? Did the symptoms develop within minutes of specific activities or exposure at work? Is there a history of a high level acute exposure? Do delayed symptoms occur? Describe them. Do symptoms occur less frequently or not at all on days away from work and on vacation? Do symptoms occur more frequently on returning to work? Is there any history of atrophy? Describe this. Is there a smoking history? Is there an occupational history?

PHYSICAL EXAMINATION:

Results of a complete physical examination with emphasis on the respiratory system.

LABORATORY: (If performed)

Dynamic pulmonary function tests with and without bronchodilators? Static pulmonary function tests including DLCO. Inhalation challenge testing? Results of skin testing? RAST tests? (Please provide copies of reports) Results of peak expiratory flow rates while at work and away from work. Copies of MSDS for substances used at work? Results of recent industrial hygiene surveys for the workplace.

THERAPY:

Medications? Respirator use? Restriction? (Please describe)

DISABILITY INFORMATION SHEET
FOR OCCUPATIONAL LUNG DISEASE

Fax-Back #233

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

When did the respiratory symptoms begin? Describe their nature. (i.e. wheezing, cough, chest tightness, chest pain, shortness of breath, etc.) Please describe their frequency and severity? Did the symptoms develop after starting a new job or after new materials were introduced? Did the symptoms develop within minutes of specific activities or exposure at work? Is there a history of a high level acute exposure? Do delayed symptoms occur? Describe. Do symptoms occur less frequently or not at all on days away from work and on vacation? Do symptoms occur more frequently on returning to work? Any history of atopy? Describe. Smoking history? Occupational history?

PHYSICAL EXAMINATION:

Results of a complete physical examination with emphasis on the respiratory system.

LABORATORY STUDIES: (If performed)

Dynamic pulmonary function tests with and without bronchodilator? Static pulmonary function tests including DLCO. Inhalation challenge testing? Results of skin testing? RAST tests? Results of peak expiratory flow rates while at work and away from work. Copies of MSDS for substances used at work? Results of recent industrial hygiene surveys for the work place.

THERAPY:

Medications? Respirator use? Restrictions? (Please describe) Hospitalizations and consultations? (Please provide copies of discharge summaries and consultative reports.)

DISABILITY INFORMATION SHEET
FOR OCCUPATIONAL SKIN DISEASE

Fax-Back #241

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

Please describe the chronological sequence of events surrounding the onset of the skin disease, its subsequent clinical course and associated work activities of the applicant. Provide a description of the skin lesions and their initial anatomic location(s) and spread to other body sites. Please describe the disability caused by the skin disease. Please identify all relevant work exposures. Are similar skin lesions present in co-workers? What has been the response to previous medical treatment. Did the skin disease improve while the applicant was performing modified work activities or not working? Is there any history of personal or family atopy or allergies? Was there any antecedent skin disease or reactions?

PHYSICAL EXAMINATION:

What is the morphological appearance of the skin lesions? What is the anatomical distribution?

LABORATORY STUDIES: (If performed)

Results of patch testing. Results of biopsies. (Please provide copies of reports).

THERAPY:

Medications? Engineering controls in the work place? Protective clothing? Gloves? Barrier creams? Skin hygiene and cleansing? Response to therapy? (Please describe).

DISABILITY INFORMATION SHEET
FOR PHLEBITIS & VENOUS INSUFFICIENCY

Fax-Back #237

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

Any history of thrombophlebitis? Number and dates of episodes? Any history of pulmonary embolism? Number and dates? Any history of heart disease? Describe. History of edema of the lower extremity?

PHYSICAL EXAMINATION:

Height and weight? Edema? How much? Varicosities? Describe. Any skin changes (e.g. thin, shiny, atrophic, etc.) Eczema? Number, size & location of ulcerations?

LABORATORY STUDIES: (If performed)

Plethysmography? Ultrasound? Venogram? (Please provide copies of reports.)

THERAPY:

Weight reduction (if indicated). Medications? Elastic stockings? Bed rest? Elevation of the leg(s)? Unna cast? Surgical procedures (Please include copies of operative reports) Hospitalizations (Please include copies of discharge summaries) Restrictions?

DISABILITY INFORMATION SHEET FOR PSYCHIATRIC DISORDERS

Fax-Back #250

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY			
	Date of onset of disease		Drug or alcohol abuse history
	Symptoms which fulfill the diagnostic criteria of DSM-III-R		Other

PHYSICAL FINDINGS			
	Signs that fulfill the diagnostic criteria of DSM-III-R		Other physical findings that may affect the ability to work or recovery from the psychiatric condition.
			Other

LABORATORY STUDIES			
	Personality testing		Neuropsychiatric testing
	Tests of cognitive function		Intellectual testing
	Educational evaluation		Other

THERAPY			
Frequency and dosage should be described. Describe response to therapy and the patient's compliance with therapy.			
	Medications		Prognosis
	Psychotherapy		Restrictions
	Summaries of hospitalizations		Work evaluation reports
	Rehabilitation progress notes		Other

DISABILITY INFORMATION SHEET
FOR RENAL DISEASE

Fax-Back #238

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

Any history of renal disease (e.g. infections, vascular, nephrotoxicity, immune, metabolic, congenital, obstructive uropathy, etc.? Please describe in detail.) Any weakness? Easy fatiguability? Headaches? Anorexia? Nausea and vomiting? Polyuria? Nocturia? Hypertension? Weight loss? Diarrhea? Itching? Paresthesia? Seizures? Visual difficulties? Pulmonary edema? Congestive heart failure? Bleeding diatheses?

PHYSICAL EXAMINATION:

Pallor? Hyperpnea? Uremic breath? Dehydration? Excoriated skin? Purpura? Hypertension? Retinopathy? Cardiac enlargement? Pulmonary edema? Peripheral neuropathy?

LABORATORY STUDIES: (If performed)

CBC? Bleeding time? Urinalysis? BUN? Creatinine? Uric acid? Serum sodium? Potassium? Calcium? Magnesium? Plasma bicarbonate? Creatinine clearance? Chest X-ray? EKG? CT Scan? MRI? Renal biopsy? Other? (Please provide copies of reports).

THERAPY:

Diet? Fluid intake? Electrolyte replacement? Medications? Dialysis? Kidney transplant? Other?

DISABILITY INFORMATION SHEET FOR RESPIRATORY DISEASE

Fax-Back #252

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY			
	Dyspnea (whether at rest, on exercise, how many blocks can be walked, how many stairs walked up, orthopnea).		Cough (productive vs. Non-productive, in the morning, when lying down, hemoptysis, etc.)
	Pnumothorax, pleurisy, pneumonia, etc.		Chest pain (When, where, what makes it better or worse?)
	Wheezing (time of day, week, etc.)		Smoking history (packs-years)
	Allergic history(hay fever, eczema, etc.)		Occupational history
			Other

PHYSICAL FINDINGS			
	Chest size, shape, and motion		Pheripheral edema
	Cyanosis		Are friction rubs, rales, rhonchi, wheezing present? If so, do they clear up on coughing? Are there differences between lungs?
	Liver enlargement		Clubbing of fingers
	Distended neck veins		Are there areas of dullness, increased or decreased breath sounds present?
			Other

LABORATORY STUDIES			
	Chest X-rays		Exercise tests
	Electrocardiogram		Arterial blood gases
	Dynamic pulmonary function tests:		CT Scan
	FVC, FEVI, FEF 25-75		Inhalation challenge testing
	Without bronchodilators		Skin testing
	With bronchodilators		RAST tests
	Methacholine challenge		Bronchoscopy
	Airway resistance		Bronchograms
	Static pulmonary function tests:		Sputum cytology
	Lung volumes		Pathology
	Compliance		
	Closing volume		
	Carbon monoxide diffusing capacity		Other

THERAPY			
Frequency and dosage should be described. Describe response to therapy and the patient's compliance with therapy.			
	Medications (bronchodilators, antibiotics, etc.)		Operative summaries
	Oxygen requirements		Restrictions
	Chest physiotherapy		Please explain the physiologic basis for your restrictions.
	Summaries of hospitalizations		Other

DISABILITY INFORMATION SHEET FOR RHEUMATOID ARTHRITIS

Fax-Back #239

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

When did symptoms first develop? Prodromal history malaise? Fever? Weight loss? Joint stiffness? (If joint stiffness is present, when is it worst? How long does it last? What help it? What aggravates it?) Which joints are involved? Any history of vasomotor disturbances, e.g. paresthesia, Raynaud's phenomenon, etc.? Any family history of arthritis? (If so, please describe.)

PHYSICAL EXAMINATION:

Specify which joints are involved and whether there is any tenderness, increased warmth, effusion, deformity and/or synovitis for each joint involved? Range of motion in degrees of each joint involved? Flexion contracture? Muscle atrophy? Palmar erythema? Any subcutaneous nodules? Any dryness of mucus membranes? Ocular changes? Any peripheral neuropathy?

LABORATORY STUDIES: (If performed)

Rheumatoid Factor? ANA? Sedimentation Rate? CBC? X-rays and other imaging studies? (Please provide copies of reports)

THERAPY:

Braces and splints? Exercises? Physical modalities such as heat and cold? Medications?

PROGNOSIS:

Please describe the clinical course, e.g. progressive v. exacerbations and remissions.

DISABILITY INFORMATION SHEET
FOR SEIZURE DISORDERS

Fax-Back #240

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s)0. Specific information is needed regarding:

HISTORY:

When did the seizures start? Any family history of seizures? Any history of trauma at birth? History of alcohol or drug ingestion? Focal features? (Please describe). Any history of stroke, encephalitis or meningitis? Any abdominal pain, nausea, dizziness, behavioral disturbances or automatism? (Please describe in detail). Any deja vu phenomenon? Have the seizures been witnessed? Frequency per week of seizures? Duration of seizures? Any bowel or bladder incontinence during the seizure? Any postictal confusion or fatigue? (Please describe).

PHYSICAL EXAMINATION:

Results of a complete neurological examination.

LABORATORY STUDIES: (If performed)

Results of EEG? MRI of the brain? CT Scan of the brain? Lumbar puncture? (Please provide copies of reports).

THERAPY:

Medications? (Please describe). Hospitalizations? (Please provide copies of discharge summaries and admission history & physical examination summaries).

DISABILITY INFORMATION SHEET FOR SYSTEMIC LUPUS ERYTHEMATOSUS

Fax-Back #234

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

Any history of fever? Anorexia? Weight loss? Malaise? Hair loss? Raynaud's phenomenon? fingertip lesions, e.g. periungual erythema, splinter hemorrhages, etc.? Skin lesions? (Please describe). Arthralgia? Conjunctivitis? Photophobia? Visual blurring? Pleurisy? Pneumonitis? Pericarditis? Cardiac arrhythmias? Abdominal pain? Depression? Convulsive disorders? Neuropathies? Renal disease? How long have each of these been present?

PHYSICAL EXAMINATION:

Results of a complete physical examination.

LABORATORY STUDIES: (If performed)

ANA? (If positive, describe pattern.) Sedimentation rate? CBC? Urinalysis? Liver function studies? Renal function studies? Antiphospholipid antibodies? EKG? Chest X-ray? Pulmonary function studies? (Please provide copies of reports).

THERAPY:

Medications? (Please describe). Sun blocks and protective clothing, if photosensitive? Please describe the response to therapy. Restrictions?

DISABILITY INFORMATION SHEET FOR THORACIC SPINE DISORDERS

Fax-Back #242

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this checklist to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s).

HISTORY:

_____ What sort of activity or motion caused the initial attack?

_____ Describe the nature, location and severity of symptoms.

_____ Are they intermittent or constant?

_____ Do they change with coughing, sneezing, straining at stool?

_____ What activities help and which aggravate symptoms?

_____ Is there radiation of the pain? Where? Is it lancinating?

_____ Is there paresthesia? Where?

_____ Is there pain when the patient arches backward?

PHYSICAL FINDINGS:

____ Patient's weight, height and body build.

_____ Alignment of the spine straight? Any scoliosis?

_____ Location and severity of tenderness, if any? Is it diffuse or localized to one structure? Is the skin tender to pinch?

_____ Presence and location of spasm, if present?

____ Range of motion of the spine in degrees.

_____ Results of congruency tests? (e.g. Axial loading, rotation, distraction, etc.)

_____ Results of tests of sensation? (Touch, pinprick, position, temperature and vibration). Location and distribution. Is it dermatomal?

_____ Deep tendon reflexes

_____ Babinski

DISABILITY INFORMATION SHEET FOR VERTIGO

Fax-Back #243

NAME:_____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

When did the vertigo start? Is the patient spinning or are things spinning around him? In which direction does the spinning occur? What is the frequency of vertiginous episodes? What is their duration? What helps and what aggravates these episodes? Does the patient fall with these episodes? Does nausea accompany the vertigo? Any tinnitus? Hearing loss? Any vomiting? Any URI's, trauma, inflammatory processes, etc. prior to developing vertigo? Any family history of hearing disorders? Any history of cardiovascular disease or hypertension? Any history of neurological disorders? Any ear fullness, ear pressure, ear pain, etc., ? Any otorrhea?

PHYSICAL EXAMINATION:

Complete ENT examination? Complete cardiovascular system examination? Complete neurological examination? Any spontaneous nystagmus? If present, please describe. With 20 diopter glasses? Describe the gait? Romberg test results? Heel to toe walking? Any positional nystagmus, e.g. Dix Hallpike test?

LABORATORY STUDIES: (If performed.)

Electronystagmography? X-rays? MRI? Brain stem auditory evoked response? CT Scan? Audiogram? Blood chemistries? Hematological studies? Sedimentation rate? ANA? (Please provide copies of reports.)

THERAPY:

Medications? Diet? Exercises? Operative procedures? Hospitalizations? Etc.? (Please provide copies of hospitalization discharge summaries, operative reports, etc.)